MEMORANDUM

To: Division of Medical Assistance
Claims Analysis Unit

From: _____ Telephone Number: _____

_____ County Department of Social Services

Date: _____

Re: Request for Claims Override

COMPLETE ALL PERTINENT SECTIONS

Recipient: _____ **MID**: _____

Date of Application: _____ Date of Disposition: _____

Reason for override request: **(There are NO other acceptable reasons.)**

[ ] Social Security/SSI disability approval after a Medicaid disability denial:

[ ] SSA/SSI disability denial (adopted by Medicaid) subsequently reversed by SSA.
Onset of disability: _____

Date notice of approval received by dss: _____

Authorization limited to the later of the date of application or onset of disability.

[ ] Medicaid disability denial (not adopted SSA/SSI decision) subsequently approved by SSA. Onset of disability: _____

Date county dss learned of SSA/SSI approval: _____

Authorization limited to 12 months prior to the county's learning of SSA/SSI approval.

[ ] County/State hearing decision in favor of the a/r.

Date DSS-1894 "Notice of Decision" received by dss: _____

[ ] Court order in favor of the a/r.

[ ] County administrative error. Date error discovered by dss: _____

Cause of error: _____

Authorization limited to 12 months prior to discovery of error.

[ ] Application opened/reopened when the applicant was discouraged from applying, encouraged to withdraw an application, or the application was improperly denied.

[ ] County dss learned of approval of an SSI/SDX application.

Eligible dates in EIS for which override is needed: _____
Send notice of override approval to: [ ] Recipient [ ] Responsible person
Responsible person: Name _____
Address _____

_____

To: _____Department of Social Services

From: Claims Analysis Unit
Division of Medical Assistance

Recipient:_____MID:_____

I. OVERRIDE APPROVAL

Override authorization is **approved** for this recipient for the following date(s):

_____

_____

Advise the recipient to inform all medical providers to file outstanding claims directly with EDS, the Medicaid contractor, no later than _____

If the recipient is deceased or otherwise unable to notify providers, the IMC must follow procedures in MA-2395/MA-3395, V.I.D.7.b

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II. OVERRIDE DENIAL

The override request is **denied** for all or part of the date(s) because:

[ ] Failure of the provider to file timely is not a basis for override.

[ ] The claims filing time limit has not expired. No override is needed.

[ ] The request does not meet policy guidelines. See M-AABD, MA-2395 or FC, MA-3395. Advise providers to submit claims to DMA, Claims Analysis Unit, for special handling within 45 days of date of decision indicated below.

[ ] Other:_____

_____

_____

_____ _____

Date Claims Analyst, DMA

Rev. 03/01/97

III. MA-2395/MA-3395-Figure 1